

## **A New Reflexivity: Why Anthropology Matters in Contemporary Health Research and Practice, and How to Make it Matter More**

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Many of medical anthropology's leading lights are currently lamenting the undervalued place of ethnographic work in public health and medicine. Vincanne Adams argues that in the field of global health, demands for randomized, controlled studies have become an "empirical tyranny" (Adams 2010:48). And Joao Biehl and Adriana Petryna assert that "ethnographic evidence consistently *dies* within the dominant conceptual paradigms of global health" (Biehl and Petryna 2013:16).

This argument seems incomplete to us. Based on our experience publishing and collaborating with health professionals in two very different arenas—global polio eradication, and veteran-oriented health services research—we have come to believe that anthropologists now have an unprecedented opportunity to contribute to the creation of clinical and public health structures more deeply informed by core anthropological concerns. Anthropological theory has a powerful grasp of the connection between broad-scale social structures and intimate lived realities, and its methods are perhaps unequaled in capturing the nuances of context.

But making the most of anthropology's particular strengths will require overcoming a series of challenges, particularly in how we as anthropologists communicate with other health professionals. In this commentary, we first discuss our observations on anthropology's unique value in contemporary health research and practice and then offer a few suggestions for how to make the most of our contribution. Ultimately, we contend that making sure anthropology has a place at the table with public health and medicine will require a new reflexivity, a careful examination of the biases and conventions of our discipline.

### **What Anthropology Brings to the Table**

#### **1. Anthropologists have a sophisticated and rigorous ethnographic approach.**

Let's start with the obvious. Anthropology has a valuable set of tools for understanding the world—tools that are needed in public health and medicine. We have a long history of commitment to rich, deep ethnographic work. We've also spent decades thinking and

writing about positionality, bias, and validity. Most of us have a highly developed awareness of both the power and limits of the work we do.

However, much qualitative work in public health and medicine falls short of anthropological standards; it is often carried out quickly and based primarily on interviews. Participant observation is rare. Many qualitative health researchers don't know how to take fieldnotes, and many are MDs or other health care providers who never received in-depth training in qualitative research. Some have not been trained to consider what validity and bias mean in the qualitative context.

Given all this, it is easy to understand why many within public health and medicine might think qualitative methods are flimsy. While it is true that such research is sometimes discounted in public health and medicine, one reason for this is that some of it isn't very good.

So anthropology has an enormous amount to contribute here. Anthropologists' commitment to truly informed ethnography brings valuable tools to the table—tools many public health researchers are sincerely interested in. For example, in a recent collaborative research project, Svea and a group of researchers studied health systems in eight districts in Sub-Saharan Africa and South Asia (Closser et al. 2012; Closser et al. 2014). What particularly caught public health officials' eye were case studies of ways to strengthen health systems. The case studies were classic ethnography, written with a careful eye to agency and power. The research project in question had both quantitative and qualitative components, but it was the ethnography, not the statistical analysis, that was picked up and circulated by immunization planners.

## **2. Anthropology understands context.**

A particular strength of ethnographic work is its power to illuminate cultural, political, and historical context. This makes anthropology valuable for understanding human behavior and experience, including health and illness, in an interconnected world where change is rapid and continual.

One example of anthropology's particular relevance to questions facing contemporary health care is the problem of understanding the adoption and spread of clinical practices for screening, prevention, and treatment. There is frequently a gap of years – sometimes decades - between identification of a practice that is useful and effective in reducing suffering and widespread use of that practice by providers. So striking is this gap that an entire interdisciplinary field has sprung up to examine it, most commonly called “implementation science”. Despite the relative lack of visibility of implementation science within anthropology, anthropologists have been on the forefront of growing the field (Huertin-Roberts, Hamilton, and Finley 2013). It has become a central tenet of implementation science that, when it comes to understanding what people do or do not do, context is all.

For one example, we can look to the U.S. Veterans Affairs (VA), which maintains the largest integrated healthcare system in the United States and is also a significant employer of anthropologists (Sobo 2013). Erin and others have been using implementation science perspectives within VA to study the adoption of new psychotherapies demonstrated to help veterans with posttraumatic stress disorder (PTSD). These therapies have demonstrated effectiveness in both clinical and real-world settings around the world, and are promoted in international guidelines, but until recently were rarely utilized by psychotherapy providers in the United States. The reasons for this include cultural and contextual issues specific to the US, like the nature of training, organizational policy, and care providers' beliefs about the treatments' relative benefit and potential harms (Cook, Dinnen, Thompson, Simiola, and Schnurr 2014; Finley et al. 2015). Lessons learned from investigating these kind of contextual factors are being used to continually refine how VA delivers therapy for PTSD.

Bringing an anthropological eye to context – to understanding how clinics, health systems, or other kinds of social organizations work, and to identifying the characteristics of those organizations that support innovation and growth – can greatly increase the potential for positive change.

### **3. Anthropology has great theory.**

Few of anthropology's central concepts, including culture and ethnicity, have remained within the field. The ideas of syndemics, medicalization, and stigma, to name just a few, are now fully embraced by most public health and medical professionals. But it remains true that anthropologists typically understand and use these concepts with more depth and nuance.

For instance, cultural competence is valued, if not always achieved, within modern medicine and public health--an outcome of both their humanistic orientation and of decades spent realizing that health interventions delivered without cultural awareness are likely to fail. But anthropology has the longest and most sophisticated history of engaging with that concept and seeking to understand it, warts and all. Moreover, many of the questions at the heart of contemporary anthropology – like how cultural thinking reflects structural circumstances, how culture changes over time, and how individuals navigate within culture to make high-stakes decisions – have immediate relevance for health.

Building on this kind of anthropological lens, another VA anthropologist, Heather Reisinger, has been working with a team to study how a so-called “tele-ICU”—a system linking patients and care providers at rural Intensive Care Units—works in practice. They found that integrating “tele-ICUs” into rural hospitals was complex and potentially disruptive, particularly since nurses and doctors at the rural hospitals reasonably feared that the tele-ICU was a mechanism of surveillance and control (Moeckli et al. 2013). Their recommendations on, among other things, how to build supportive relationships rather than systems experienced as “spies in the sky” were widely circulated at the VA and used to help strengthen the fledgling initiative.

#### **4. Anthropology turns its critical lens back on health systems themselves.**

Being an anthropologist at the table with public health and medical professionals does not necessitate losing a critical perspective or becoming a cog in the wheel of problematic projects. Anthropologists have long critically examined the structure and practices of public health and medical institutions themselves (Justice 1986; Pfeiffer 2003; Singer 1998), and know full well that public health and medical projects may reinforce rather than alleviate inequalities. Frequently, public health and medical practitioners are aware of this too. Our experience is that the problems we identify are ones that many public health practitioners, with their backgrounds in health inequalities and social justice, are open—enthusiastic, even—to learning more about.

A strong example of this is the thoughtful, critical work done by the Ebola Response Anthropology Platform (Chandler et al. 2015). These researchers (in their words) “scrutinise some of the assumptions about current Ebola social mobilisation strategies.” They ask critical questions about education strategies—for example, about whether improved knowledge really will lead to behavior change. Some of these questions would feel familiar to most in public health.

But the authors also push the envelope by looking critically at how and by whom Ebola messaging has been created and disseminated: they are productively critical about the very structures of public health programs. Their work is explicitly anthropological—few public health practitioners think and write in quite this way.

But many in public health and medicine are open to thinking in these terms. These anthropologists published their critical observations in the *Lancet*, the flagship global public health and medical journal, with an impact factor around 15 times that of *American Anthropologist*.

#### **Anthropology *at* the Table**

So anthropology’s well-informed critical perspective has a lot to offer public health and biomedical healthcare delivery. What, then, of Biehl and Petryna’s argument that ethnographic evidence isn’t taken seriously in public health?

We think they have a point. Anthropological research is sometimes discounted or disregarded in public health and medicine. Not always, to be sure—the discussion above contains a number of examples of times when anthropologists were heard and their thoughts widely disseminated—but too often.

We think the responsibility for this lies not just in global health and medicine, but also in anthropology, and particularly in how anthropologists communicate their work. We need to communicate with applied health fields the same way we would ask health professionals

to communicate with our ethnographic participants: in thoughtful, culturally appropriate language, with an eye to their needs and perspectives and the resources they have within reasonable access.

When this is done, it is our experience that public health and medical professionals listen. Ensuring that anthropology has a place at the table, then, requires a concerted effort to adopt a new reflexivity, and to move the field forward in five key ways.

### **1. Communicate in accessible language.**

Anthropologists often write for an audience of other professional anthropologists. We use language to signal affiliations, and we use particular words as shorthand for complicated theoretical ideas. This works if all we want to do is write to each other (which is a perfectly laudable goal). But it doesn't work if we want to communicate to people trained in other disciplines. And such writing makes it all but out of the question for people like district-level health staff in poor countries to engage with our work. If people are to listen to us, they need to understand what we're saying.

Inspiring models of transparent, clear, compelling writing exist. Claire Wendland's (2010) *A Heart for the Work* is a model, an elegant book that consistently avoids obfuscation without sacrificing theoretical rigor, and which easily reaches across disciplinary boundaries.

### **2. Work on problems with obvious relevance.**

Many anthropologists, even those avoiding jargon, have had the experience of explaining their work to health types only to be met with glazed eyes. There are myriad questions of great fascination in anthropology – including those we've embraced in our own work – that do not directly facilitate a more effective response to a given health concern. To take an example from Erin's work, the question of how the act of defining traumatic illness reflects cultural approaches to suffering and violence may be interesting, but it does almost nothing to help front-line providers figure out how to improve access to care for combat veterans. Developing a more nuanced understanding of how stigma discourages veterans from seeking care, however, is immediately and obviously useful.

When we are able to apply our expertise to pressing, actionable problems, we are more likely to find a receptive audience for our work. As just one example, the VA values its growing number of anthropologists to such an extent that the national head of health services research, Dr. David Atkins, attended the 2014 SFAA meetings to serve as panel discussant. Atkins used his time at the podium to praise the work being done by VA anthropologists. At the same time, in comments published after the meeting, Atkins made a point of saying that "insight is overrated" and "To truly be of value, anthropologists need to turn their insights into recommendations for action or tools to help the people trying to understand and shape culture."

It is worth emphasizing that the ultimate value of anthropological work should not be judged based on its perceived utility among non-anthropologists. Ours is a gloriously diverse discipline, and anthropologists can and should do anthropology for anthropologists. We must be able to choose our own methods and areas of study, and to do anthropology for its own sake. Nonetheless, there are times when it is appropriate to look first to what contribution we want our work to make, and to focus our efforts on the area of greatest need in a clear and demonstrable way.

### **3. Ground work in rigorous and transparent methodology.**

The cultures of public health and medical research value clear, transparent descriptions of methodology. At public health conferences, it is common for well over half of a presentation to be devoted to methodology, empowering the audience to make their own judgment regarding the validity and utility of the data. So when anthropologists write papers or give presentations in which methodology is glossed over with just a passing reference to participant observation, the work is frequently—and unfortunately—written off by health practitioners as being perhaps not particularly rigorous or sophisticated.

In some cases, an underlying problem is that anthropologists may not always be as proficient with qualitative methodology as we like to claim. As qualitative methods have acquired greater authority, so too have they acquired a proliferating number of practitioners across a wide range of fields: sociology, business and marketing, organization science, folklore, communications, medicine, nursing, and so on. Anthropologists working in applied settings will – sooner rather than later – be asked to articulate their methodological choices and rationale to an audience quite capable of educated critique. To the extent that anthropologists choose to emphasize methodological expertise as one of our contributions beyond our own field, we need to be prepared to speak and act as experts.

Being explicit about our methods can only be to the good. Most obviously, it facilitates acceptance of anthropological work in public health and medical journals. But beyond that, explicit discussion of methodology, including positionality, methods of analysis, and potential biases, makes our work more robust. One great example of transparency in methods is the methodological appendix in the collaborative ethnography *The Secret* (Hirsch et al. 2010). It is precise, comprehensive, and detailed enough that it can be used by others who want to adapt their methods.

### **4. Get the facts right.**

In conducting ethnographic work that focuses on health institutions, and then asking the people inside those institutions to take our results seriously, we face an enormously high bar for accuracy. We are presenting our results to the natives. If any of the information that we relate in our analysis is wrong, the natives will quickly -- and fairly -- write us off as uninformed. Anthropologists who desire to engage with health organizations and

practitioners must demonstrate an informed understanding of their workings and worlds in order to be heard.

There is a structural problem to this, however, in that most anthropologists working in academia have demanding teaching schedules and squeeze in fieldwork over the summer months or winter break. There is often limited time to do participant observation in the structures that provide health care. Health practitioners, in contrast, live in these structures. In some cases, they created them. If anthropologists have the hubris to argue that they have new knowledge or perspectives to share, they must first demonstrate they know health care structures at least as well as those working within them.

It is therefore essential to be meticulous about our facts. Even mild inaccuracies undermine our credibility. Precise descriptions alive to the nuances of context establish it.

Many anthropologists, of course, do a beautiful job at this. Just one example is the work of Judith Justice, which grows out of a commitment to informed ethnography. She double-checks all of her information from multiple sources. She builds relationships with health practitioners and runs her work by them to make sure that her descriptions are correct. She has a great reputation in public health—people listen to her—and her reputation is in large part built on the fact that she knows what she's talking about.

In presenting factual information that will be taken seriously, time and tense present a particular challenge (but one, happily, easily fixed). In too much medical anthropological writing, we use the ethnographic present to describe fieldwork done as much as 10 or even 15 years ago. Use of the ethnographic present in such cases can easily result in errors of fact and interpretation, describing what-once-was-but-is-no-longer-true. Again, the reasons for this are often structural; many of us have fascinating data we don't have time to write up right away. We may even tell ourselves that the particulars of whether this was happening 10 years ago or last month don't really matter in terms of the larger patterns at play, which is what we are really interested in.

But for health practitioners—who are trying to do the best they can *today*, not ten years ago—writing about bygone political and funding structures as if they are current makes anthropologists seem sloppy and uninformed at best and completely clueless at worst.

The solution to this is not to throw out our old data. The larger structures that caused problems ten years ago are still very much alive, and history does often repeat itself. But we should project our awareness that 10 years ago, and 5 years ago, are not today. We should use past tense, and be alive to the political-economic context of the time we are writing in.

When we speak to the carefully gathered facts of the current time, we more immediately build a solid base upon which to be taken seriously.

## **5. Be mindful of anthropological biases.**

If we were to argue at this point that the field of anthropology has particular biases that influence its way of viewing the world, it would likely seem both obvious and unpersuasive, for the field is so diverse that it is nearly impossible to characterize. Moreover, the relative perspective on whether “bias” is a bad thing also varies tremendously; one anthropologists’ bias is another’s Umwelt, as becomes immediately clear when the question of whether anthropology should consider itself a science arises. Nonetheless, it seems relatively safe to say that most anthropologists care deeply about finding and speaking to truth, in all its myriad forms.

Toward that end, we also urge anthropologists to be mindful of their own biases, particularly those that might be considered shared cultural tendencies of the field. Though this is a warning that has been put forward before (Bolton 1995), it bears repeating. Common biases include those emerging from our methodologies, particularly as outsiders not always well-integrated into the societies under study; our philosophical leanings, including the tendency to romanticize the exotic over the mundane and the marginal over the mainstream; and our professional conventions, which tend to preference the elegantly articulated over the ruthlessly triangulated.

In short, while anthropology has done an admirable job in the post-modern era of encouraging reflexivity at the individual level, we have not always been so active in examining our disciplinary biases and how they impact the quality and utility of our work. Now would be an opportune time to engage in a new reflexivity.

## **6. Provide recommendations for action.**

Describing problems is straightforward for anthropologists. Our theoretical background, and our propensity to talk to people without much power, give us a framework for quickly seeing the ways that public health and medical institutions uphold structures of inequality.

But if finding problems is easy—we are good at it, and this is truly a strength of the field—then writing recommendations is hard. We anthropologists are acutely attuned to all of the ways our recommendations can go wrong. But when speaking to health professionals – many of whom make potentially life-altering decisions on a regular basis – we need to be more courageous about actually making recommendations for a better way forward. Health practitioners can’t do much with our work if we refuse to tell them what to do better. And sometimes, making recommendations – and acknowledging the responsibility that entails – can help us to be more attuned to the pressures our target audience faces.

When we do provide recommendations, the response can be gratifying. A classic example is Kleinman’s *Illness Narratives*, which advocated listening closely to patient narratives to better understand the place of illness within an individual’s life and life course (Kleinman 1988). In the intervening years, American healthcare has developed an entire subfield of narrative medicine that aims to do precisely that.



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Taken together, these steps do not entail a dumbing-down of our work, or a compromise of our critical edge. Rather, clear and thoughtful attention to methods, and greater rigor and clarity in describing social realities, will lead to anthropological work that is more robust, better supported, and better positioned to speak in compelling ways to important public issues.

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